

CALIFORNIA'S HEALTH

WILTON L. HALVERSON, M.D.
DIRECTOR OF PUBLIC HEALTH

STATE DEPARTMENT OF PUBLIC HEALTH
ESTABLISHED APRIL 15, 1870

PUBLISHED SEMI-MONTHLY

SAN FRANCISCO 2, 760 MARKET STREET

ENTERED AS SECOND-CLASS MATTER JAN. 25, 1949, AT THE POST OFFICE AT SAN FRANCISCO, CALIFORNIA, UNDER THE ACT OF AUG. 24, 1912. ACCEPTANCE FOR MAILING AT THE SPECIAL RATE APPROVED FOR IN SECTION 1103, ACT OF OCT. 3, 1917

VOLUME 6, NUMBER 17

MARCH 15, 1949

STATE BOARD OF PUBLIC HEALTH

DR. CHARLES E. SMITH, President
San Francisco

DR. JAMES F. RINEHART, Vice President
San Francisco

DR. ELMER BELT
Los Angeles

DR. HARRY E. HENDERSON
Santa Barbara

DR. SANFORD M. MOOSE
San Francisco

DR. ERROL R. KING
Riverside

DR. SAMUEL J. MCCLENDON
San Diego

DR. WILTON L. HALVERSON,
Executive Officer
San Francisco

ANN WILSON HAYNES, Editor
JEROME GROSSMAN, Assistant

A Proposed Program of Student Health Services in California State Colleges

ALVIN LEONARD, M.D., Medical Officer,
Bureau of Adult Health

Upon request of the State Department of Education, the State Department of Health has undertaken a survey of state colleges in California.* The purpose of the study has been to determine the needs of student health services, both present and future, in the various institutions, how these needs are being met at the present time, and how they may best be met in future years as the colleges expand. Estimates of student population in 1965 are derived from "A Report of a Survey of the Needs of California in Higher Education" which was submitted to the Liaison Committee of the Regents of the University of California and the State Department of Education by Drs. Monroe E. Deutsch, Aubrey A. Douglass, and George D. Strayer.

Each of the nine colleges was visited, its present program and facilities reviewed, and conferences held with responsible administrative officials. The results of the survey are presented in this report.

The ultimate objective of any student health service is to maintain a state of optimum health, both physical and emotional, among the student body and to indoctrinate each student with the proper attitudes and habits regarding personal and community health. It is believed that a program to achieve this objective is a reasonable insurance of the huge investment which California is making in the education of a large group of its future leaders. Specifically, an adequate student health service coordinates the activities of health service and

health education, provides a healthful school environment, discovers physical and emotional defects in an early, correctable stage, conserves students' time by preventing and treating acute illnesses, and excludes contagious diseases from the campus.

There is a wide variety among the student health services as now provided in the state colleges. Some institutions provide a fairly adequate program, financed largely by student fees, and some have extremely inadequate programs. In none of the colleges is there a service comparable with that offered by the University of California. There is no statement in the Education Code that defines the responsibility of the state colleges in this field, other than a provision that makes it mandatory for a person to pass a physical examination before receiving a teaching credential.

In general, the activities of the student health service fall into four categories: Preventive medical services, environmental sanitation, integration of health education and health services, and provision of medical care. The following discussion is based largely on recommendations that were made at the Third National Conference on Health in Colleges held in New York in May, 1947, sponsored by a large number of organizations and federal agencies, including the American Student Health Association and the National Health Council, and attended by a large number of educators, physicians, and nurses working in student health. Co-sponsors included the American Medical Association, American Dental Association, and the American Public Health Association.

* State Colleges surveyed were: Humboldt, Sacramento, Chico, San Jose, California Polytechnic, San Francisco, Los Angeles, San Diego. Specific recommendations for each of the colleges were a part of the report made to the Department of Education, but are not included here.

Physical Examination

Every college should provide a complete physical examination of all new students, which should be mandatory for matriculation. This examination, including the chest X-ray and urinalysis, determines the physical fitness of the student for undertaking his academic program, finds communicable diseases such as tuberculosis, and discovers correctable defects that may be unknown to the student.

Provision should be made for re-examination of certain students when medically indicated. Athletes should be examined at the beginning of each training season; teacher training candidates should be examined annually as a health education experience; students preparing to enter professional schools should be examined during their senior year at college in order to determine physical fitness for an intensive study schedule; and students returning to school after absence due to illness should receive a physical examination.

Following the physical examination, conferences between the student and the physician are essential for the purpose of discussing defects and guiding the student into proper channels for correction. To assure that correctable defects are remedied, an organized follow-up is of the utmost importance. Student-physician conferences should be made available to all students who wish to discuss matters of physical or mental health, or related problems, such as marriage or fitness for certain vocations.

Public Health Measures

Provision of a healthful environment on the campus is clearly a responsibility of the college administration. This includes a program of supervision of water and food supply, sewage and garbage disposal, student housing, and classroom lighting, ventilation and heating. The director of the student health service should be named as the campus public health officer, and should have a sanitarian on his staff who is responsible for campus sanitation. Assistance should be secured from the local health department whenever possible in carrying out the sanitation program of the college. Food handlers should be required to have a chest X-ray prior to employment and annually thereafter; it is recommended that courses in the sanitary aspects of food handling be made mandatory for food handlers.

Immunization against smallpox should be compulsory for all students. Immunization against other diseases should be given as indicated; for example, students in bacteriology who may be working with typhoid organisms should be immunized against typhoid fever.

Chest X-ray facilities should be made available, and an annual film made mandatory for the students; faculty and other employees should be encouraged to have

a chest X-ray annually. X-rays may be provided by the local tuberculosis and health associations or local health department; if not, the mobile units of the State Health Department are recommended for this purpose.

Close liaison with local health department is most desirable in the control of communicable disease, including the follow-up of contacts and the detection of carriers.

Health Education

It is recommended that very close integration be established between health education as given in the classroom and health services. This may be achieved if some classroom instruction is given by a school physician and by personnel of the local health department. Every visit to the college health center should be an educational experience for the student. There is also need for integration between health services and the guidance and counseling service with cross referrals and frequent consultation between the two regarding special problems of students. An active health council consisting of the president of the college, the director of student health services, the deans of men and women, the local health officer, the dean of guidance and counseling, and any other personnel who may be responsible for any phase of student health, has proved most useful in many colleges.

Medical Services and Facilities

The extent of provision of medical care varies considerably in institutions of higher learning. The University of California maintains a fully equipped and staffed hospital that gives almost complete care; the director of this service is the immediate past president of the Alameda County Medical Society. In contrast, many of the state colleges provide practically no care at the present time. Most of the colleges plan to provide dormitory facilities for resident students in the next few years, a fact which will increase the schools' responsibility for student health.

Every college should maintain a health center consisting of an out-patient department and an infirmary for overnight bed care. Even for minor illnesses, bed care in a dormitory or residence hall is unsatisfactory because of lack of proper food and nursing. In the areas where the state colleges are located, only 40 to 80 percent of the community needs for hospital beds are being met; therefore, it is not feasible for the college to hospitalize cases of minor illness in community hospitals. The infirmary and the out-patient department should be centrally located and housed in the same structure so that both may use the same equipment.

In the report of the Third National Conference on Health in Colleges, it is recommended that the infirmary contain from five to twenty beds per 1,000 students,

depending on the proportion of day to resident students. Since the majority of the students in most of the state colleges are not living too far from home, it is recommended that from five to seven beds per 1,000 students be provided. In event of an acute epidemic of influenza or other epidemic disease, it may be found necessary to convert a dormitory into a temporary infirmary to care for the large number of patients. In the infirmary there should be separate wings for men and women students, and provisions should be made for a small diet kitchen. Only minor office surgery should be performed on the campus. Other surgery, and complex medical problems, should receive care in local community hospitals.

The health center should be centrally located, close to the administration building, the guidance and counseling offices, and easily accessible to the students. If it is located at some distance from the gymnasiums, provision should be made for emergency first aid care in the gymnasiums. The health center should be equipped with an X-ray unit and darkroom, basal metabolism equipment, electro-cardiogram, physical therapy equipment such as infra-red lamps, audiometer, and equipment for dental and visual examination. There should be a reception room, adequate lavatory facilities for men and women, dressing rooms for men, women, nurses and doctors, from two to six professional offices for medical work with washbowl and examination table in each. There should be rooms, separate for men and women, where students may rest when necessary for an hour or two. The estimated space requirement of the out-patient department is between 4,000 and 5,500 square feet, depending on the number of professional rooms, which will vary with the size of the college.

Personnel

The Third National Conference on Health in Colleges recommends the equivalent of one full-time physician per 1,000 students. The director of the student health service should be a full-time employee. The other physicians in the student health service may be part-time physicians who are also practicing in the community. In most cases it will be found necessary to obtain the services of additional physicians during the period of examination of entering students. Provision should also be made for securing the services of specialists for consultation when necessary.

In the out-patient department, provision should be made for one nurse for each physician, and it is desirable to have at least one public health nurse on the staff. Infirmarys will require one nurse for every 15 beds, on an eight hour basis, or a total of three nurses, plus provision for relief, for every 15 beds.

Enough secretarial help should be provided so that professional time is not spent on clerical matters. An adequate record system should be maintained, including records of morbidity, absences due to illness, medical services dispensed, and an individual medical record for each student. The need for auxiliary personnel, such as technicians and dieticians, must also be met in each college.

Costs

The cost of operation of a student health service as outlined above is estimated, by the Third National Conference on Health in Colleges, to be about \$15 per student per year. If major surgery, prolonged hospitalization, or elaborate treatment is offered, the cost will be close to \$30 per student per year. One way of financing the operation of the student health service is to charge a small health fee to cover part of the operating expenses, with college funds covering the remainder.

The usual practice in college is not to include faculty members and other employees in the student health service since they are permanent residents of the community. However, this group should be checked for communicable diseases such as tuberculosis, and should be eligible for emergency and first aid care as the need arises.

Bibliography

1. *A Health Program for Colleges*. Report of the Third National Conference on Health in Colleges, National Tuberculosis Association, 1948.
2. Diehl, H. S., and Shepard, C. E., *The Health of College Students*. The American Council on Education, 1939.
3. *Suggested School Health Policies*. National Conference for Cooperation in Health Education. Distributed by American Medical Association, 1946.
4. Smiley, Dean F., and Hein, Fred V., *Physicians and Schools*. Distributed by American Medical Association, 1948.

Bill Would Create Federal Department of Welfare

Under terms of H. R. 782 now being considered by Congress, a Department of Welfare would take over functions of the present Federal Security Agency.

The bill, only 55 lines long as introduced, provides that the Secretary of Welfare "shall have the duty of fostering and promoting the general welfare of the people of the United States in matters pertaining to their health, education, social welfare and social security, including the duty of studying and making recommendations and disseminating information with respect to such matters."

Also called for in the measure is the appointment of an under secretary and two assistant secretaries "each of whom shall perform such duties as the secretary shall direct."

A report on Nine Health Education and Nutrition Workshops

A report on nine workshops held in various parts of the country in 1947 has been issued by General Mills, sponsor of the project, in a booklet entitled "Workshop Experiences in Learning to Build a Nutrition and Health Education Program." The publication is available in California from the Sperry Division of General Mills Inc., 116 New Montgomery St., San Francisco.

The study groups operated with the cooperation of State Departments of Education, State Universities, State Colleges and other interested groups and attempted to provide an in-service program for elementary school teachers which would be of value in their nutrition and health education classroom work.

Contained in the booklet are an outline of workshop procedures and suggestions for school programs including a section on criteria for evaluating them.

One part of the report which can be applied to workshops on any subject was the section on discussion type procedures. The participants thought these to be good group procedures:

1. *Round table discussion* accomplished more if each individual member acted as a resource person and assumed responsibility for a small part of the discussion.

2. *Talks by consultants* gave more to the group if a discussion period followed immediately. If reading were done in advance so that each participant was familiar with the subject that was to be discussed, more would be gained from the consultant's presentation.

3. *Panel discussions* should be arranged so that members are selected from a large group, thus giving each workshop member an opportunity to participate. Panel meetings meant more to the group if they followed some introduction of a subject, rather than gave the initial presentation.

4. *Demonstrations* were suggested where they could be given in a normal, natural situation. If children were to be included, it was thought better procedure to have small groups visit the laboratory school rather than to bring the children to the workshop classroom for a demonstration.

If demonstrations were to be made with materials, the materials should be simple and such that they would be available to schools throughout the year. In other words, demonstrations should be practical.

Demonstrations should show everyday experiences, but introduce little-known or new approaches or factual informations. For example, many children had made cottage cheese in classrooms, but few children knew whey had a yellow color because of riboflavin, one of the B vitamins.

* 5. *Quiz programs* were the basis for discussion on some of the workshops, while others used quiz programs to review information pertinent to material being developed. Children's quiz programs, where laboratory schools were in progress, were reported as a good means of interesting children in nutrition information.

Citizens of Duarte Take a Hand in Improving Health Conditions

Seeking to better the health conditions of their community, the citizens of Duarte, an unincorporated area of Los Angeles County, have undertaken a concerted program for expansion of local public health services.

The program, called the "Duarte Project," is being spearheaded by the community service council, an organization including the community's voluntary groups, official school, health and recreation agencies and private citizens.

Original impetus for the project was a study of services available through the county health department, local schools and voluntary agencies.

A preliminary report of progress issued by the community service council* listed the following action which has thus far resulted from the program:

1. Establishment of a branch health office staffed to give this service.
 - a. Inspection of any suspected case of communicable disease or health program of any kind, and referral to a physician or clinic for diagnosis and treatment.
 - b. Counseling for expectant mothers and babies.
 - c. Immunization for diphtheria, smallpox, whooping cough, typhoid fever, and rabies.
 - d. Readmission to school of children excluded because of a communicable disease.
 - e. Ringworm inspection.
 - f. Health education.
2. Extension of visiting nurse association services.
3. A house to house sanitation survey and subsequent assistance to residents in improving conditions.
4. Formulation of a Duarte health education project for the schools.
5. Completion of a community chest X-ray survey.

The Duarte Project reports the council "is an experiment in coordinated, cooperative service to all the citizens of the community." It seems to be accomplishing its purpose remarkably well.

* Duarte Newsletter, November, 1948.

The American Red Cross issued over a million certificates in First Aid, Water Safety and Accident Prevention during the last fiscal year.

California 1947 Crude Death Rate Lowest on Record

California, with a crude death rate of 9.9 in 1947, the lowest on record for the State, was one of 12 states that had lower rates in 1947 than in 1946 according to a recent release of the U. S. National Office of Vital Statistics. The crude death rate of 10.1 for the United States in 1947 was the second lowest on record; the rate of 10.0 for 1946 was the lowest. Five states showed no change in rate between 1946 and 1947; the remaining 31 showed increases. These rates are by place of residence and are per 1,000 estimated total population exclusive of the armed forces overseas.

Crude death rates reflect differences in age-race-sex composition of the population as well as differences in health conditions. This should be kept in mind in comparing rates of different states.

Crude death rates of 10.0 and over, in general, were in the New England, Middle Atlantic, North Central, and some of the Mountain States. The frequency distribution of states according to their crude death rates is as follows:

| Crude death rate | Number of states |
|------------------|------------------|
| 11.0 and over | 12 |
| 10.0-10.9 | 11 |
| 9.0-9.9 | 17 |
| 8.0-8.9 | 6 |
| under 8.0 | 2 |

The crude death rate for California residents reported by the U. S. National Office of Vital Statistics is slightly higher than the crude death rate of 9.7 for California computed by the State Department of Public Health for 1947. The crude death rate of 9.9 is for deaths of all California residents while the rate computed by the state office is for residents who died within the State. Other slight differences in the number of deaths reported by these two agencies are due to differences in methodology, such as the use of year of registration by the state office and year of death by the National Office of Vital Statistics. The number of deaths reported by the U. S. National Office of Vital Statistics is 96,697 for California in 1947 as compared with 95,231 reported by this agency. The National Office of Vital Statistics reported that 95,407 deaths of California residents occurred in California and 1,290 deaths occurred in other states. However, the trend of the crude death rate is not affected by these differences.

Crude Death Rates, United States, Each Division and State, 1944-1947

(Exclusive of stillbirths and of deaths among armed forces overseas. By place of residence)

| Area | 1944 | 1945 | 1946 | 1947 |
|----------------------|------|------|------|------|
| United States | 10.6 | 10.6 | 10.0 | 10.1 |
| New England | 12.2 | 11.9 | 11.1 | 10.9 |
| Maine | 12.9 | 12.5 | 11.7 | 11.3 |
| New Hampshire | 13.3 | 12.5 | 11.9 | 11.6 |
| Vermont | 13.6 | 12.3 | 11.8 | 12.0 |
| Massachusetts | 12.5 | 12.3 | 11.4 | 11.2 |
| Rhode Island | 11.1 | 10.9 | 10.9 | 11.2 |
| Connecticut | 10.8 | 10.8 | 10.0 | 9.7 |
| Middle Atlantic | 11.8 | 11.8 | 10.8 | 10.8 |
| New York | 11.9 | 12.0 | 11.1 | 11.1 |
| New Jersey | 11.6 | 11.6 | 10.3 | 10.4 |
| Pennsylvania | 11.8 | 11.7 | 10.6 | 10.5 |
| East North Central | 11.2 | 11.2 | 10.4 | 10.5 |
| Ohio | 11.7 | 11.5 | 10.5 | 10.7 |
| Indiana | 11.3 | 11.4 | 10.4 | 10.6 |
| Illinois | 11.6 | 12.0 | 11.2 | 11.2 |
| Michigan | 10.1 | 9.9 | 9.4 | 9.4 |
| Wisconsin | 10.7 | 10.9 | 10.3 | 10.2 |
| West North Central | 10.7 | 10.8 | 10.1 | 10.3 |
| Minnesota | 10.1 | 10.2 | 9.5 | 9.6 |
| Iowa | 11.0 | 10.8 | 10.1 | 10.2 |
| Missouri | 11.6 | 11.8 | 11.1 | 11.4 |
| North Dakota | 10.0 | 10.0 | 9.5 | 9.7 |
| South Dakota | 10.5 | 10.2 | 10.0 | 9.9 |
| Nebraska | 10.2 | 10.2 | 9.7 | 10.0 |
| Kansas | 10.2 | 10.3 | 9.6 | 9.7 |
| South Atlantic | 9.5 | 9.5 | 9.1 | 9.4 |
| Delaware | 12.2 | 12.0 | 11.5 | 11.5 |
| Maryland | 11.3 | 11.4 | 10.3 | 10.5 |
| District of Columbia | 9.2 | 9.6 | 9.8 | 9.6 |
| Virginia | 9.4 | 9.8 | 9.4 | 9.7 |
| West Virginia | 9.7 | 9.8 | 8.9 | 9.1 |
| North Carolina | 8.2 | 8.2 | 7.8 | 8.2 |
| South Carolina | 9.3 | 8.9 | 8.6 | 8.8 |
| Georgia | 9.4 | 9.4 | 8.8 | 9.2 |
| Florida | 10.3 | 9.9 | 10.3 | 10.4 |
| East South Central | 9.8 | 9.8 | 9.3 | 9.6 |
| Kentucky | 10.7 | 10.7 | 10.0 | 10.2 |
| Tennessee | 9.7 | 9.9 | 9.2 | 9.2 |
| Alabama | 9.5 | 9.5 | 8.8 | 9.3 |
| Mississippi | 9.2 | 9.1 | 9.4 | 9.6 |
| West South Central | 8.9 | 8.7 | 8.4 | 8.7 |
| Arkansas | 7.9 | 8.0 | 7.6 | 7.9 |
| Louisiana | 9.4 | 9.2 | 8.7 | 9.2 |
| Oklahoma | 9.1 | 8.6 | 8.1 | 8.5 |
| Texas | 9.0 | 8.8 | 8.6 | 8.8 |
| Mountain | 10.2 | 10.4 | 9.8 | 9.9 |
| Montana | 12.5 | 12.1 | 11.7 | 11.8 |
| Idaho | 8.4 | 8.8 | 8.8 | 9.1 |
| Wyoming | 8.7 | 8.9 | 8.1 | 8.9 |
| Colorado | 11.0 | 11.6 | 10.6 | 11.0 |
| New Mexico | 10.6 | 10.7 | 10.4 | 10.0 |
| Arizona | 10.4 | 10.7 | 9.6 | 9.4 |
| Utah | 8.3 | 8.1 | 7.5 | 7.8 |
| Nevada | 11.4 | 11.3 | 11.3 | 11.7 |
| Pacific | 10.4 | 10.2 | 9.9 | 9.6 |
| Washington | 10.4 | 10.1 | 9.6 | 9.3 |
| Oregon | 10.1 | 9.9 | 9.3 | 8.7 |
| California | 10.4 | 10.2 | 10.0 | 9.9 |

NOTE: Rates are per 1,000 estimated total midyear population present in the area as published in U. S. Bureau of the Census, "Current Population Reports: Population Estimates," Series P-25, No. 12, 1948.

SOURCE: U. S. National Office of Vital Statistics, Vital Statistics—Special Reports, National Summaries, 1947, Vol. 31, No. 1 (February 8, 1949), Table 2, p. 7.

Tuberculosis Survey of California Mental Institutions

The discovery of 2,139 previously unsuspected reinfection type cases of pulmonary tuberculosis is an 11-month casefinding program in seven California mental hospital was reported in the January 7, 1949, issue of *Public Health Reports** by Dr. Waldo R. Oechsli of this department's Bureau of Disease Control.



Dr. Waldo Oechsli

Dr. Oechsli's paper was used as the basis for an editorial in the same issue calling on all public health officials to do their utmost in finding ways of controlling tuberculosis in the Nation's mental institutions.

California's tuberculosis control program in the state institutions was formulated as a cooperative venture by the State Departments of Public Health and Mental Hygiene in 1943 and was initiated in 1944 with preliminary mass X-ray surveys of all patients and employees. It was placed on a continuing basis in 1946.

Underlying the need for some action was the tuberculosis death rate of over 600 per 100,000 resident population in seven California hospitals for the mentally ill, and a death rate of nearly 400 per 100,000 in resident population in two institutions for mentally defectives.

* Tuberculosis control program of nine California mental institutions, results of initial chest X-ray survey, p. 4.

Surveys are conducted by mobile units of the State Department of Public Health.

All active cases found in the surveys thus far undertaken have been segregated as have been some patients with questionably active or potentially communicable disease. Patients with inactive disease were left on nontuberculous wards but checked periodically by X-ray.

In the surveys undertaken, tuberculosis was discovered among 2.7 percent of the employees of mental hospitals and among 1.4 percent of the individuals working in institutions for mental defectives.

The California experience, Dr. Oechsli concludes, means that "in order to improve conditions in mental institutions, it is necessary to do a thorough X-ray survey of all patients, to X-ray all new admittances, and to segregate all patients with communicable tuberculosis. Such surveys must be repeated annually for a considerably period of time."

U. C. Postgraduate Medical Course

"Psychiatry and neurology" will be the subjects of a full-time 12-week post-graduate medical course to be offered by the U. C. Medical School in San Francisco from August 29 through November 18, 1949.

The course, which will make use of the facilities of the Langley-Porter Clinic, will be under the direction of Karl M. Bowman, M.D.

Fee for the program will be \$200.

Those interested in further information are asked to communicate with Dr. Stacy R. Mettier, Head of Postgraduate Instruction, Medical Extension, University of California Medical Center, San Francisco 22.

Annual Report Appears in Series of Newspaper Ads

A unique twist to the business of getting an annual report before the public has recently been tried by the health department of Lawrence-Wabash County, Illinois.

The report was presented in the form of four advertisements in local newspapers. It covered the year's activities under such dramatic headlines as:

"Action for Health"

"Polio—The Pearl Harbor of Public Health"

"Declaration of War on Disease"

"The Atomic Bomb of Public Health"

The last headline, incidentally, referred to health education.

Following their appearance in the press, the articles were reprinted in pamphlet form.

A Health Center for Napa County



Pictured here is the new \$41,000 Napa County Health Center which was dedicated last December.

The structure was built to house the first full-time health department in the county's history.

Gathered in front of the mural on dedication day were (from left to right) James H. Millage, contractor; Dr. Kenneth Haworth, Napa County Health Officer; Russell G. DeLappe, architect and county planning consultant; Thomas Markwell, then chairman of the county board of supervisors; Rev. Joseph Gist and Dr. Edward S. Rogers, Dean of the U. C. School of Public Health.



Photographs are from the *Napa Register*.

In 75 disasters affecting 35 states and the District of Columbia during the fiscal year ending June 30, 1948, a total of 1,621 nurses were recruited and served in American Red Cross disaster operations.

Continuous Filing in These Classes

Until further notice, the State Personnel Board is accepting continuously applications for the positions listed below. When examinations are officially announced, accepted applicants will be notified when and where to report for their tests.

Physician and Surgeon
Senior Physician and Surgeon
Public Health Medical Officer, Grade 1
Public Health Medical Officer, Grade 2
Public Health Nurse
Clinical Laboratory Technician

Further information is available from the State Personnel Board, 1015 L Street, Sacramento.

New Imperial Health Officer

Dr. C. R. Kroeger has replaced Dr. Burke E. Schoensee as health officer of Imperial County.

Dr. Kroeger's headquarters will be the Court House in El Centro.

Index to Volume 5 Ready

The index to Volume 5 of *California's Health* (July 1947-June 1948) is now ready for distribution.

Requests should be directed to: Bureau of Health Education, State Department of Public Health, 760 Market Street, San Francisco 2, California.

Causes of Death by Age Group California, 1947

Cancer, pneumonia, influenza, tuberculosis, accidents and diseases of the heart are important causes of death in practically every age group of Californians.

This is the main fact brought out by the Bureau of Records and Statistics in the tabulation of causes of death by age group for the soon-to-be-released *Statistical Supplement* to the annual report of the State Department of Public Health for the 1947-48 Fiscal Year.

Here is a preview of some of the things the table will show:

Five Leading Causes of Death and Total Deaths for Each Age Group, California, 1947

| Cause of death | Number | Percent |
|--|--------|---------|
| Under 1 Year | | |
| Total, all causes | 7,204 | 100.0 |
| Premature birth (cause not stated) | 2,548 | 35.4 |
| Congenital malformations | 1,032 | 14.3 |
| Injury at birth | 948 | 13.2 |
| Other prenatal and natal causes | 694 | 9.6 |
| Pneumonia, all formations, and influenza | 693 | 9.6 |
| 1-4 Years | | |
| Total, all causes | 1,103 | 100.0 |
| Accidents, exclusive of motor vehicle | 189 | 17.1 |
| Pneumonia, all forms, and influenza | 131 | 11.9 |
| Motor vehicle accidents | 120 | 10.9 |
| Cancer and other malignant tumors | 95 | 8.6 |
| Congenital malformations | 94 | 8.5 |
| 5-9 Years | | |
| Total, all causes | 490 | 100.0 |
| Accidents, exclusive of motor vehicles | 102 | 20.8 |
| Motor vehicle accidents | 98 | 20.0 |
| Cancer and other malignant tumors | 67 | 13.7 |
| Pneumonia, all forms and influenza | 24 | 4.9 |
| Congenital malformations | 19 | 3.9 |
| 10-14 Years | | |
| Total, all causes | 357 | 100.0 |
| Accidents, exclusive of motor vehicles | 85 | 23.8 |
| Motor vehicle accidents | 62 | 17.4 |
| Cancer and other malignant tumors | 36 | 10.1 |
| Tuberculosis, all forms | 21 | 5.9 |
| Diseases of the heart | 21 | 5.9 |
| 15-19 Years | | |
| Total, all causes | 899 | 100.0 |
| Motor vehicle accidents | 285 | 31.7 |
| Accidents, exclusive of motor vehicle | 164 | 18.2 |
| Tuberculosis, all forms | 100 | 11.1 |
| Diseases of the heart | 50 | 5.6 |
| Cancer and other malignant tumors | 35 | 3.9 |
| 20-24 Years | | |
| Total, all causes | 1,233 | 100.0 |
| Motor vehicle accidents | 387 | 31.4 |
| Tuberculosis, all forms | 227 | 18.4 |
| Accidents, exclusive of motor vehicle | 153 | 12.4 |
| Cancer and other malignant tumors | 71 | 5.8 |
| Suicide | 60 | 4.9 |
| 25-34 Years | | |
| Total, all causes | 3,204 | 100.0 |
| Motor vehicle accidents | 486 | 15.2 |
| Tuberculosis, all forms | 430 | 13.4 |
| Accidents, exclusive of motor vehicle | 374 | 11.7 |
| Cancer and other malignant tumors | 324 | 10.1 |
| Diseases of the heart | 270 | 8.4 |

| | | |
|--|--------|-------|
| 35-44 Years | | |
| Total, all causes | 5,755 | 100.0 |
| Diseases of the heart | 1,086 | 18.9 |
| Cancer and other malignant tumors | 913 | 15.9 |
| Tuberculosis, all forms | 589 | 10.2 |
| Motor vehicle accidents | 438 | 7.6 |
| Accidents, exclusive of motor vehicle | 428 | 7.4 |
| 45-54 Years | | |
| Total, all causes | 10,782 | 100.0 |
| Diseases of the heart | 3,356 | 31.1 |
| Cancer and other malignant tumors | 2,134 | 19.8 |
| Tuberculosis, all forms | 676 | 6.3 |
| Intracranial lesions of vascular origin | 595 | 5.5 |
| Cirrhosis of the liver | 490 | 4.5 |
| 55-64 Years | | |
| Total, all causes | 17,100 | 100.0 |
| Diseases of the heart | 6,632 | 38.8 |
| Cancer and other malignant tumors | 3,465 | 20.3 |
| Intracranial lesions of vascular origin | 1,257 | 7.4 |
| Nephritis | 681 | 4.0 |
| Tuberculosis, all forms | 584 | 3.4 |
| 65 and Over¹ | | |
| Total, all causes | 47,104 | 100.0 |
| Diseases of the heart | 20,461 | 43.4 |
| Cancer and other malignant tumors | 7,029 | 14.9 |
| Intracranial lesions of vascular origin | 5,427 | 11.5 |
| Nephritis | 2,318 | 4.9 |
| Other diseases of the circulatory system | 2,315 | 4.9 |

¹ Includes 30 deaths of unknown age.

California Morbidity Reports Selected Diseases—Civilian Cases

Total Cases for January, 1949, 1948, 1947, and
5-Year Median (1944-1948)

| Selected diseases | Current month—January | | | 5-year median 1944-1948 |
|--|-----------------------|-------|-------|-------------------------------|
| | 1949 | 1948 | 1947 | |
| Chickenpox (varicella) | 4,470 | 4,045 | 4,225 | 4,043 |
| Coccidioid granuloma | 4 | 3 | 5 | |
| Conjunctivitis—acute infectious of the newborn (ophthalmia neonatorum) | — | — | 2 | |
| Diphtheria | 43 | 51 | 106 | 127 |
| Dysentery, bacillary | 32 | 17 | 16 | |
| Encephalitis, infectious | 2 | 3 | 4 | 3 |
| Epilepsy | 201 | 178 | 148 | |
| Food poisoning | 2 | 9 | 63 | |
| German measles (rubella) | 630 | 177 | 177 | |
| Influenza, epidemic | 106 | 6,343 | 63 | 2,305 |
| Jaundice, infectious | 17 | 10 | 6 | |
| Malaria | 3 | 8 | 11 | |
| Measles (rubeola) | 3,052 | 2,484 | 603 | 2,610 |
| Meningitis, meningococcal | 27 | 53 | 40 | |
| Mumps, (parotitis) | 3,546 | 1,973 | 1,497 | 2,436 |
| Pneumonia, infectious | 159 | 250 | 295 | 421 |
| Poliomyelitis, acute anterior | 196 | 13 | 79 | 21 |
| Rabies, animal | 20 | 40 | 32 | 40 |
| Rheumatic fever | 44 | 77 | 64 | |
| Scarlet fever | 433 | 409 | 632 | 586 |
| Streptococcal sore throat | 71 | 70 | 51 | |
| Smallpox (variola) | — | — | — | |
| Tuberculosis: | | | | |
| Pulmonary | 634 | 633 | 699 | 630 |
| Other forms | 36 | 41 | 36 | 41 |
| Typhoid fever | 10 | 20 | 6 | |
| Typhus fever | — | — | 4 | |
| Undulant fever (brucellosis) | 3 | 19 | 19 | 19 |
| Whooping cough (pertussis) | 228 | 409 | 517 | 517 |
| Veneral diseases: | | | | |
| Chancroid | 42 | 26 | 69 | |
| Gonococcus infection | 1,953 | 2,310 | 3,456 | 2,467 |
| Granuloma inguinale | 2 | 6 | 6 | |
| Lymphogranuloma venereum (lymphopatia venereum, lymphogranuloma inguinale) | 9 | 21 | 26 | |
| Syphilis | 1,182 | 1,441 | 2,528 | 2,248 |

0
0
2
6
4
S
E
F
V
pr
th
pr
fir
ca
fo
nu
Sy
m
ye
ca
ca
fa
ter
pe
by
an
see
the
ass
an
tha
rea
the
Se
all
ele
the
Bar